General Assembly

Raised Bill No. 5009

February Session, 2012

LCO No. **93**

00093_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING THE RATE APPROVAL PROCESS FOR CERTAIN HEALTH INSURANCE POLICIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-481 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions **[**which**]** that are unfair or deceptive or **[**which**]** that encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer **[**which**]** that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval,

and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) (1) No rate filed under the provisions of subsection (a) of this section shall be effective **[**until the expiration of thirty days after it has been filed or**]** unless **[**sooner**]** approved by the commissioner. **[**in accordance with regulations adopted pursuant to this subsection.**]** The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory, **[**. The**]** as described in section 7 of this act. Except as specified in subdivision (2) of this subsection, the commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards. **[**, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.**]**

(2) Any rate filed under the provisions of subsection (a) of this section for an individual health insurance policy that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall be approved, disapproved or modified in accordance with section 7 of this act.

(c) (1) No rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(2) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity **[**which**]** that delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

[(d) Rates on a particular policy form will not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner which meets the requirements of subsection (e) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates also will not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

(e) Premium rates shall be deemed approved upon filing with the Insurance Commissioner if the filing is accompanied by a loss ratio guarantee. The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain as a minimum the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

(3) A guarantee that the actual Connecticut or nation-wide loss ratio

results, as the case may be, for the experience period at issue will be independently audited by a certified public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period;

(4) A guarantee that affected Connecticut policyholders will be issued a proportional refund, which will be based on the premiums earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio referred to in subdivision (1) of this subsection. If nation-wide loss ratios are used, the total amount refunded in Connecticut shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned from all Connecticut policyholders who will receive refunds and divided by the total premium earned in all states on the policy form. The refund shall be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more. The refund shall include interest, at six per cent, from the end of the experience period until the date of payment. Payment shall be made during the third quarter of the year following the experience period for which a refund is determined to be due;

(5) A guarantee that refunds less than two dollars will be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center;

(6) A guarantee that the insurer, if directed by the Insurance Commissioner, shall withdraw the policy form and cease the issuance of new policies under the form in this state if the applicable loss ratio exceeds the durational target loss ratio for the experience period by

more than twenty per cent, provided the calculations are based on at least two thousand policyholder-years of experience either in Connecticut or nation-wide.

(f) For the purposes of this section:

(1) "Loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations; and

(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.**]**

[(g)**]** (d) Nothing in this chapter shall preclude the issuance of an individual health insurance policy **[**which**]** that includes an optional life insurance rider, provided the optional life insurance rider **[**must**]** shall be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

[(h)**]** (e) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity that delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state shall: (1) Move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole; or (3) use an individual's history of taking a prescription drug for anxiety for six months or less as a factor in its underwriting unless such history arises directly from a medical diagnosis of an underlying condition.

Sec. 2. Section 38a-501 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) (1) As used in this section, "long-term care policy" means any individual health insurance policy **[**,**]** delivered or issued for delivery to any resident of this state on or after July 1, 1986, **[**which**]** that is designed to provide, within the terms and conditions of the policy, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after an elimination period (A) not to exceed one hundred days of confinement, or (B) of over one hundred days but not to exceed two years of confinement, provided such period is covered by an irrevocable trust in an amount estimated to be sufficient to furnish coverage to the grantor of the trust for the duration of the elimination period. Such trust shall create an unconditional duty to pay the full amount held in trust exclusively to cover the costs of confinement during the elimination period, subject only to taxes and any trustee's charges allowed by law. Payment shall be made directly to the provider. The duty of the trustee may be enforced by the state, the grantor or any person acting on behalf of the grantor. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy **[**which**]** that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center

delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694 solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy **[**which**]** that has a loss ratio of less than sixty per cent for any individual long-term care policy. An issuer shall not use or change premium rates for a long-term care insurance policy unless the rates have been filed with and approved by the Insurance Commissioner in accordance with section 7 of this act. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. A rate filing shall include the factors and methodology used to estimate irrevocable trust values if the policy includes an option for the elimination period specified in subdivision **[**(2)**]** (1) of subsection (a) of this section.

(c) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair disclosure of the benefits and limitations of the policy. If the offering for any long-term care policy includes an option for the elimination period specified in subdivision **[**(2)**]** (1) of subsection (a) of this section, the application form for such policy and the face page of such policy shall contain a clear and conspicuous disclosure that the irrevocable trust may not be sufficient to cover all costs during the elimination period.

(d) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy on or after July 1, 2008, without offering, at the time of solicitation or application for purchase or sale of such coverage, an option to purchase a policy that includes a nonforfeiture benefit. Such offer of a nonforfeiture benefit may be in the form of a rider attached to such policy. In the event the nonforfeiture benefit is declined, such company, society, corporation or center shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates. Not later than July 1, 2008, the Insurance Commissioner shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection. Such regulations shall specify the type of nonforfeiture benefit that may be offered, the standards for such benefit, the period of time during which a contingent benefit upon lapse will be available and the substantial increase in premium rates that trigger a contingent benefit upon lapse in accordance with the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners.

(e) The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, **[**which**]** that address (1) the insured's right to information prior to his replacing an accident and sickness policy with a long-term care policy, (2) the insured's right to return a long-term care policy to the insurer, within a specified period of time after

delivery, for cancellation, and (3) the insured's right to accept by **[**his**]** the insured's signature, and prior to it becoming effective, any rider or endorsement added to a long-term care policy after the issuance date of such policy. The Insurance Commissioner shall adopt such additional regulations as **[**he**]** the commissioner deems necessary in accordance with chapter 54 to carry out the purpose of this section.

(f) **[**The**]** Except for the requirement under subsection (b) of this section that rates be approved in accordance with section 7 of this act, the Insurance Commissioner may, upon written request by any such company, society, corporation or center, issue an order to modify or suspend a specific provision of this section or any regulation adopted pursuant thereto with respect to a specific long-term care policy upon a written finding that: (1) The modification or suspension would be in the best interest of the insureds; (2) the purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and (3) (A) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care, (B) the policy is to be issued to residents of a life care or continuing care retirement community or other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such community, or (C) the modification or suspension is necessary to permit long-term care policies to be sold as part of, or in conjunction with, another insurance product. **[**, whenever**]** Whenever the commissioner decides not to issue such an order, **[**he**]** the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(g) Upon written request by any such company, society, corporation or center, the Insurance Commissioner may issue an order to extend the preexisting condition exclusion period, as established by regulations adopted pursuant to this section, for purposes of specific age group categories in a specific long-term care policy form whenever **[**he**]** the commissioner makes a written finding that such an extension is in the best interest to the public. Whenever the commissioner

decides not to issue such an order, **[**he**]** the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(h) The provisions of section 38a-19 shall be applicable to any such requesting party aggrieved by any order or decision of the commissioner made pursuant to subsections (f) and (g) of this section.

Sec. 3. Section 38a-513 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) No group health insurance policy, as defined by the commissioner, or certificate shall be **[**issued or**]** delivered or issued for delivery in this state unless a copy of the form for such policy or certificate has been submitted to and approved by the commissioner **[**under the regulations adopted pursuant to this section**]** and, with respect to a group health insurance policy for a small employer, as defined in section 38a-564, a copy of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. If the commissioner issues an order disapproving the use of such form, the provisions of section 38a-19 shall apply to such order.

The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) (1) No rate filed under the provisions of subsection (a) of this section shall be effective unless approved by the commissioner. The

commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory, as described in section 7 of this act. Except as specified in subdivision (2) of this subsection, the commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards.

(2) Any rate filed under the provisions of subsection (a) of this section for a group health insurance policy for a small employer that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 shall be approved, disapproved or modified in accordance with section 7 of this act.

[(b)**]** (c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate.

[(c)**]** (d) Nothing in this chapter shall preclude the issuance of a group health insurance policy **[**which**]** that includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

[(d)**]** (e) Not later than January 1, 2009, the commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits in group specified disease policies, certificates, riders, endorsements and benefits.

Sec. 4. Subsection (a) of section 38a-183 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

(a) A health care center governed by sections 38a-175 to 38a-192, inclusive, as amended by this act, shall not enter into any agreement with subscribers unless **[**and until**]** it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the commissioner's approval **[**thereof**]** in accordance with section 7 of this act. The commissioner **[**may refuse such approval if he finds**]** shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such amounts **[**to**]** shall not be excessive, inadequate or unfairly discriminatory, as described in section 7 of this act. **[**Each**]** No such health care center shall **[**not**]** enter into any agreement with subscribers unless **[**and until**]** it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of **[**the amounts to be paid,**]** any agreement or any form, notify the health care center of **[**either his**]** the commissioner's approval or disapproval thereof.

Sec. 5. Section 38a-208 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

No such corporation shall enter into any contract with subscribers unless **[**and until**]** it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscribers and has obtained said commissioner's approval **[**thereof**]** in accordance with section 7 of this act. The commissioner **[**may refuse such approval if he finds**]** shall adopt regulations, in accordance with chapter 54, to prescribe standards to ensure that such rates **[**to**]** shall not be excessive, inadequate or unfairly discriminatory, as described in section 7 of this act. No hospital service corporation shall enter into any contract with subscribers unless **[**and until**]** it has filed with the Insurance

Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either of his**]** of the commissioner's approval or disapproval thereof.

Sec. 6. Section 38a-218 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2013*):

No such medical service corporation shall enter into any contract with subscribers unless **[**and until**]** it has filed with the Insurance Commissioner a full schedule of the rates to be paid by the subscriber and has obtained said commissioner's approval **[**thereof**]** in accordance with section 7 of this act. The commissioner **[**may refuse such approval if he finds**]** shall adopt regulations, in accordance with chapter 54, to ensure that such rates **[**are**]** shall not be excessive, inadequate or unfairly discriminatory, as described in section 7 of this act. No such medical service corporation shall enter into any contract with subscribers unless **[**and until**]** it has filed with the Insurance Commissioner a copy of such contract, including all riders and endorsements thereof, and until said commissioner's approval thereof has been obtained. The Insurance Commissioner shall, within a reasonable time after the filing of any such form, notify such corporation **[**either of his**]** of the commissioner's approval or disapproval thereof.

Sec. 7. (NEW) (*Effective January 1, 2013*) (a) (1) With respect to a health insurance policy, agreement or contract that provides coverage of the type specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469 of the general statutes, any (A) rate filed for such policy pursuant to section 38a-481 of the general statutes, as amended by this act, (B) rate filed for such policy pursuant to section 38a-501 of the general statutes, as amended by this act, (C) rate filed for such policy pursuant to section 38a-513 of the general statutes, as amended by this

act, (D) schedule of amounts filed for such agreement pursuant to section 38a-183 of the general statutes, as amended by this act, (E) schedule of rates filed for such contract pursuant to section 38a-208 of the general statutes, as amended by this act, or (F) schedule of rates filed for such contract pursuant to section 38a-218 of the general statutes, as amended by this act, on or after January 1, 2013, shall be filed not later than one hundred twenty calendar days prior to the proposed effective date of such rates or amounts.

(2) Each filer making a rate or amount filing pursuant to this section shall:

(A) On the date the filer submits such rate or amount filing to the Insurance Commissioner, clearly and conspicuously disclose to its insureds or subscribers, or in the case of a small employer group health insurance policy specified in subdivision (2) of subsection (b) of section 38a-513 of the general statutes, as amended by this act, to the policyholder for distribution to such policyholder's covered certificate holders, in writing and in such form as the commissioner may prescribe: (i) The proposed general rate or amount increase and an explanation of any increase because of the insured's, subscriber's or certificate holder's age or change in age rating classification; (ii) a statement that the proposed rate or amount is subject to Insurance Department review and approval; and (iii) detailed information on the insured's, subscriber's or policyholder's right to submit public comment to the Insurance Department, including the Internet web site, mailing address and phone number of said department and instructions on how to submit comments to the department; and

(B) Include with its rate or amount filing an actuarial memorandum, certified by an actuary in good standing with the American Academy of Actuaries, that to the best of such actuary's knowledge, (i) such rate or amount filing is in compliance with law, and (ii) the rate or amount filing is not excessive, as described in this section.

(3) (A) The Insurance Department shall post on its Internet web site

all documents, materials and other information provided to or requested by the department in relation to a rate or amount filing made pursuant to this subsection. The posting shall include all documents required by the commissioner to support such rate or amount filing, including, but not limited to, any information designated by the United States Department of Health and Human Services as necessary to ensure an effective rate review process under Section 2794 of the Public Health Service Act, 42 USC 300gg-94, as amended by Section 1003 of the Patient Protection and Affordable Care Act, P.L. 111-148, and under 45 CFR 154, as amended from time to time.

(B) The rate or amount filing and the documents, materials and other information provided to or requested by the department in relation to a rate or amount filing made pursuant to this section shall be posted not later than three business days after the department receives such filing, and such posting shall be updated to include any correspondence between the department and the filer.

(C) The department shall provide for a written public comment period of thirty calendar days following the posting of such filing. The department shall include in such posting the date the public comment period closes and instructions on how to submit comments to the department.

(b) Except where a symposium is required under subsection (d) of this section, the commissioner shall issue a written decision approving, disapproving or modifying a rate or amount filing not later than forty-five days after such filing was made. Such decision shall specify all factors used to reach such decision and shall be posted on the Internet web site of the Insurance Department not later than two business days after the commissioner issues such decision.

(c) The commissioner shall not approve a rate or amount filing made under this section if it is excessive, inadequate or unfairly discriminatory. The commissioner shall conduct an actuarial review to

determine if the methodology and assumptions used to develop the rate or amount filing are actuarially sound and in compliance with the Actuarial Standards of Practice issued by the Actuarial Standards Board.

(1) A rate or amount is excessive if it is unreasonably high for the insurance provided in relation to the underlying risks and costs after due consideration to (A) the experience of the filer, (B) the past and projected costs of the filer, and (C) other factors the commissioner deems relevant.

(2) A rate or amount is inadequate if it is unreasonably low for the insurance provided in relation to the underlying risks and costs and continued use of such rate or amount would endanger solvency of the filer.

(3) A rate or amount is unfairly discriminatory if the premium charged for any classification is not reasonably related to the underlying risks and costs, such that different premiums result for insureds with similar risks and costs.

(d) (1) (A) With respect to a health insurance policy, agreement or contract that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes, if a rate, schedule of amounts or schedule of rates filed pursuant to subdivision (1) of subsection (a) of this section (i) is for more than a ten per cent increase in such rate or amount, and (ii) the Healthcare Advocate or the Attorney General requests, not later than five business days after such rate or amount filing has been posted on the Internet web site of the Insurance Department, a symposium on such rate or amount filing, the commissioner shall, not later than five business days after the receipt of such request, set a symposium date and post the date, place and time of the symposium in a conspicuous place on the Internet web site of said department. The commissioner shall not be required to hold more than ten symposiums pursuant to this subparagraph in a calendar year.

(B) With respect to a health insurance policy, agreement or contract that provides coverage of the type specified in subdivision (8) of section 38a-469 of the general statutes, if the Healthcare Advocate or the Attorney General requests, not later than five business days after a rate, schedule of amounts or schedule of rates filed pursuant to subdivision (1) of subsection (a) of this section has been posted on the Internet web site of the Insurance Department, a symposium on such rate or amount filing, the commissioner shall, not later than five business days after the receipt of such request, set a symposium date and post the date, place and time of the symposium in a conspicuous place on the Internet web site of said department. The commissioner shall not be required to hold more than five symposiums pursuant to this subparagraph in a calendar year.

(2) (A) Such symposium shall be held not later than ninety calendar days prior to the proposed effective date of such rate or amount, at a place and time that is convenient to the public.

(B) Such symposium shall be conducted in accordance with section 8 of this act and shall not be deemed to be a contested case for purposes of chapter 54 of the general statutes.

(3) Upon setting the date, place and time of the symposium on the proposed rate or amount, the commissioner shall immediately notify the filer of the date, place and time of the symposium.

(4) Not later than thirty calendar days after the symposium, the commissioner shall issue a written decision approving, disapproving or modifying the rate or amount filing. Such decision shall specify all factors used to reach such decision and shall be posted on the Internet web site of the Insurance Department not later than two business days after the commissioner issues such decision.

(e) (1) If the Insurance Commissioner issues a decision to approve or modify a rate or amount filing made pursuant to subsection (a) of this section, the filer shall provide written notice to each insured or

subscriber, or in the case of a small employer group health insurance policy specified in subdivision (2) of subsection (b) of section 38a-513 of the general statutes, as amended by this act, to the policyholder, by first class mail that states (A) the approved rate or amount for the insured's, subscriber's or policyholder's policy or agreement, (B) any increase in the rate or amount due to the insured's, subscriber's or certificate holder's age or change in age rating classification, and (C) the percentage increase or decrease of the approved rate from the current rate of the insured, subscriber or policyholder.

(2) No such rate or amount shall be effective until thirty calendar days after the notice has been sent by the filer as set forth in subdivision (1) of this subsection or the effective date proposed under subdivision (1) of subsection (a) of this section, whichever is later.

(e) Each insurance company, health care center, hospital service corporation or medical service corporation subject to the provisions of this section shall disclose in writing to a prospective customer of a policy or agreement that may be affected by a rate or amount filing made pursuant to this section, (1) that the rate or amount of such policy or agreement is under review by the Insurance Department, and (2) the proposed increase or decrease in the rate or amount of such policy or agreement.

(f) Each insurance company, health care center, hospital service corporation or medical service corporation subject to the provisions of this section shall retain records of all earned premiums and incurred benefits per calendar year for each policy or agreement for which a rate or amount filing is made pursuant to this section. Such records shall be retained for not less than seven years after the date each such filing is made and shall include records for any rider or endorsement used in connection with such policy or agreement.

(g) The Insurance Department shall retain all records of any rate or amount filing made pursuant to this section for not less than seven years after such filing was approved, disapproved or modified.

Sec. 8. (NEW) (*Effective January 1, 2012*) (a) Each symposium held pursuant to section 7 of this act shall include an opportunity for public participation. The Healthcare Advocate or the Attorney General, or both, shall be allowed to present evidence and information at such symposium and each shall be allowed to present a closing argument in support of his or her position.

(b) The Insurance Commissioner shall assist the Healthcare Advocate or the Attorney General, or both, to obtain from the Insurance Department or the filer documents or materials related to the subject matter of the filing that are not readily available from the Insurance Department's Internet web site, provided such documents or materials are not confidential or prohibited to be disclosed by law.

(c) In making a decision to approve, disapprove or modify a rate or amount filing made pursuant to subsection (a) of this section, the commissioner shall consider any oral and written comments made or submitted at such symposium and any written public comments submitted pursuant to subparagraph (C) of subdivision (3) of subsection (a) of section 7 of this act.

Sec. 9. (NEW) (*Effective January 1, 2013*) Not later than January thirty-first, annually, the Insurance Department shall submit a report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance that lists all rates filed pursuant to section 38a-481, 38a-501 or 38a-513 of the general statutes, as amended by this act, schedule of amounts filed pursuant to section 38a-183 of the general statutes, as amended by this act, and schedule of rates filed pursuant to section 38a-208 or 38a-218 of the general statutes, as amended by this act, for health insurance policies, agreements or contracts that provide coverage of the type specified in subdivisions (1), (2), (4), (7), (11) and (12) of section 38a-469 of the general statutes, in the calendar year immediately preceding. Such report shall include the name of the filer, the per cent increase or decrease of such rate of amount filing, the per cent increase or decrease

approved by the Insurance Department, the market segment and the product type.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2013*	38a-481
Sec. 2	*January 1, 2013*	38a-501
Sec. 3	*January 1, 2013*	38a-513
Sec. 4	*January 1, 2013*	38a-183(a)
Sec. 5	*January 1, 2013*	38a-208
Sec. 6	*January 1, 2013*	38a-218
Sec. 7	*January 1, 2013*	New section
Sec. 8	*January 1, 2012*	New section
Sec. 9	*January 1, 2013*	New section

Statement of Purpose:

To require approval by the Insurance Department of rate and amount filings for certain health insurance policies, agreements or contracts; to establish procedures for symposia for certain rate or amount filings; to authorize the Healthcare Advocate or the Attorney General, or both, to participate in such symposia; to specify the amount of time the Insurance Department is required to retain certain records; and to require the department to report annually certain data pertaining to rate or amount filings.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]